

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10693

10726

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harlington Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harlington Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Leo</u> Middle <u>Blackburn</u> Last <u>Blackburn</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 11 1886</u> AGE (In years last birthday) <u>71</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sanitor in ship yard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cash Co., M.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>233-22-0739</u>	
17. INFORMANT <u>Mon Geo Blackburn</u> Address <u>Harlington Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized atherosclerosis</u> DUE TO (c) <u>10yr</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>47</u> , to <u>Oct</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 12</u> , 19 <u>57</u> , and that death occurred at <u>1 PM</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dudley Phillips MD</u> M.D. <u>Darlington Md</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Dudley Phillips MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Oct 20 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baptist Home Wilkes Co Md, C.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u> ADDRESS <u>Harlington Md</u>		24a. REC'D BY REGISTRAR <u>C. H. Kirk</u> DATE <u>Oct 21 1957</u>	
24b. REGISTRAR'S SIGNATURE			

OCT 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10693

CERTIFICATE OF DEATH

10694

Reg. Dist. No. 185-

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>1 1/2 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARTHA</u> Middle <u>AMELIA</u> Last <u>BOULDEN</u>				4. DATE OF DEATH Month <u>October</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 10, 1879</u>	
9. AGE (In years lost birthday) <u>77</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>HENRY GALLION</u>				14. MOTHER'S MAIDEN NAME <u>AURILIA WRIGHT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Clarence P. Boulden</u>		Address <u>Perryville, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis</u> <u>576X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Unknown</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardiovascular Disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10/4th</u> , 19 <u>57</u> , to <u>Oct. 6th</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct. 6th</u> , 19 <u>57</u> , and that death occurred at <u>3:31</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward C. Foo</u> M.D.				A ADDRESS (Street, city or town, state) <u>211 N. Union Ave. Perryville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Edward C. Foo, M.D.</u>				DATE SIGNED <u>10/6/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-8-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hoswell</u>		22d. LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leola Patterson</u>				ADDRESS <u>Perryville, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 10-8-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>A. L. Lewis</u>			

RECEIVED

10694

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 182

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sturgills, RD 1 Bel Air, Md.</u>		d. STREET ADDRESS <u>RD 1</u>	
3. NAME OF DECEASED (Type or print) <u>Donnie E. Brinegar</u>		4. DATE OF DEATH <u>October 10 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 26, 1957</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>✓</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>	
11. BIRTHPLACE (State or foreign country) <u>Sparta, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Gladys Brinegar</u>		14. MOTHER'S MAIDEN NAME <u>Frances Brouse</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>✓</u>		16. SOCIAL SECURITY NO. <u>✓</u>	
17. INFORMANT <u>Mr. Gladys Brinegar</u>		1340 PONTIAC AVE. BALTIMORE 25, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> <u>391.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Otitis Media</u> (a), stating the underlying cause last. DUE TO (c) <u>✓</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congenital heart disease</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> ; Accident <input type="checkbox"/> ; Suicide <input type="checkbox"/> ; Homicide <input type="checkbox"/> ; Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		DATE SIGNED <u>10-10-57</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 11/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Windsor Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sparta, N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Foster</u>		24a. REC'D BY REGISTRAR <u>10-11-57</u>	
ADDRESS <u>Broadway + Williams Streets</u>		24b. REGISTRAR'S SIGNATURE <u>Russella Lowwood</u>	
CITY <u>Bel Air, Maryland</u>			

FOR STATE
HEALTH OFF.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
OCT 15 1957
BUREAU V. S.

Handwritten text, mostly illegible due to bleed-through from the reverse side of the page. Some legible fragments include:
- "George C. [illegible]"
- "October 12, 1957"
- "Baltimore, Md."
- "Cause of death: [illegible]"
- "Manner of death: [illegible]"
- "Age: [illegible]"
- "Sex: [illegible]"
- "Race: [illegible]"
- "Occupation: [illegible]"
- "Residence: [illegible]"
- "Date of birth: [illegible]"
- "Place of birth: [illegible]"
- "Signature: [illegible]"
- "Medical Examiner: [illegible]"

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 183

10696

10695

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE 24</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>71 HARFORD MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>512 LEWIS ST. 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Marshall</u> First <u>James</u> Middle <u>Carter</u> Last			4. DATE OF DEATH <u>Oct</u> Month <u>17</u> Day <u>19</u> Year <u>57</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 15, 1889</u> 68 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Carter</u>				14. MOTHER'S MAIDEN NAME <u>Meekie Nealy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>237-14-0190</u>		17. INFORMANT <u>Jennie Carter - Haure de Grace, Md.</u> Address <u>512 Lewis St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Apoplexia</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> (c) <u>Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct. 16, 1957</u> to <u>Oct. 17, 1957</u> , that I last saw the deceased alive on <u>Oct. 17, 1957</u> , and that death occurred at <u>9:20 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Cunther D. Hirsch</u> M.D. <u>421 Congress Ave. Haure de Grace Md.</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>CUNTER D. HIRSCH</u>				<u>421 CONGRESS AVE. - HAURE DE GRACE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Oct. 20, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Methodist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Atkins J. Bullock, Haure de Grace, Md.</u>				ADDRESS <u>556 Lewis St.</u>		24a. REC'D BY REGISTRAR <u>10-20-57</u> 24b. REGISTRAR'S SIGNATURE <u>R. L. Lewis M.D.</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MAYLAND		25		F		W		1932		BALTIMORE		BALTIMORE		MD		USA	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
OCT 22 1957		10:00 AM		HOME		BALTIMORE		MD		USA		OCT 22 1957		10:00 AM		HOME	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE	
HEART DISEASE		NATURAL		Nurse		High School		Catholic		Married		1945		BALTIMORE		BALTIMORE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
OCT 22 1957		10:00 AM		HOME		BALTIMORE		MD		USA		OCT 22 1957		10:00 AM		HOME	

BUREAU V. 5

OCT 22 1957

RECEIVED

INSTRUCTIONS

1 **10727**

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The death certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10697

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bel Air</u> <u>Rural</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Street</u> <u>Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Convalescent Home</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>O'Gello</u> (First) <u>Chamburlain</u> (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>October 3</u> <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Jan. 31, 1887</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harford Co. Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Columbus Scarborough</u>				14. MOTHER'S MAIDEN NAME <u>Marj Scarborough</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. Jessie E. Scarborough</u> <u>Street Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
153X IMMEDIATE CAUSE (A) <u>Carcinoma of the transverse colon</u>						INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>None</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 1</u> , 19 <u>57</u> , to <u>October 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>October 1</u> , 19 <u>57</u> , and that death occurred at <u>10/3/57</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u> M.D.				ADDRESS (Street, city, town, state) <u>Forest Hill</u>		DATE SIGNED <u>10/3/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial Oct. 6, 1957</u>		DATE THEREOF		NAME OF CEMETERY OR CREMATORY <u>Emory Cem</u>		LOCATION (City, town, or county) (State) <u>Harford Co. Md.</u>	
24. REC'D BY REGISTRAR <u>Oct. 5, 1957</u>		REGISTRAR'S SIGNATURE <u>C. K. Kork</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>		ADDRESS <u>Parlington Md</u>	

RECEIVED

2501 01 100

BUREAU V. S.

[illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

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FOR STATE HEALTH DEPT.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10696 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10698

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford</u>		c. LENGTH OF STAY IN 1b <u>—</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01.4		d. STREET ADDRESS <u>E 25th St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James T. CINT</u>		4. DATE OF DEATH <u>October 20</u> 19 <u>57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6, 1922</u>
9. AGE (In years last birthday) <u>35</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tool Crib Att.,</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bendix Radio</u>	
11. BIRTHPLACE (State or foreign country) <u>Champaign, Ill.,</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Virgil Cint</u>		14. MOTHER'S MAIDEN NAME <u>Mildred ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WWII</u>		16. SOCIAL SECURITY NO. <u>347-12-9081</u>	
17. INFORMANT <u>Viola Cint, 35 E., 25th St., Baltimore, Md.,</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull, compound</u> <u>816 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>comminuted</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, auto-auto type</u>	
20c. TIME OF INJURY Month, Day, Year <u>12:55 a.m. 10-20-57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>u/s Route 40</u>		20f. (City or town) <u>Edgewood</u> (County) <u>Hartford</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Beltri</u> DATE SIGNED <u>10-20-57</u>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>md.</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Oct. 20, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Owens Funeral Home,</u>		22d. LOCATION (City, town, or county) (State) <u>Champaign, Champaign, Ill.,</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McComas, Jr.</u> ADDRESS <u>Abingdon, Md.</u>		24a. REC'D BY REGISTRAR <u>OCT 23 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Howard K. McComas & Son</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
OCT 23 1957
BUREAU V. E.

10697

CERTIFICATE OF DEATH

Reg. Dist. No.

10699

185

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>3 DAYS 9 HRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>WILEY</u> Last <u>COX</u>				4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC 21, 1900</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GROCERY STORE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM DAVID COX</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>ZOE E. COX (WIFE)</u>		Address <u>WHITE HALL, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension Arteriosclerosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10/16/57</u> , 19 <u>57</u> , to <u>10/20/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/20/57</u> , 19 <u>57</u> , and that death occurred at <u>3:45 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Irvin Wachsman</u>				ADDRESS (Street, city or town, state) <u>407 S. Union Ave</u>			
PHYSICIAN'S NAME (Type) <u>IRVIN WACHSMAN</u>				DATE SIGNED <u>10/21/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-23-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NEW BETHEL BAPTIST</u>		22d. LOCATION (City, town, or county) (State) <u>HOPEWELL TWP. YORK CO., PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. Cochran</u>				ADDRESS <u>Stewartstown, Penna.</u>		24a. REC'D BY REGISTRAR <u>Dr. L. Lewis</u>	
				DATE <u>OCT 25 1957</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF DEATH <i>Oct 20 1957</i>		6. TIME OF DEATH <i>10:00 AM</i>	
7. PLACE OF DEATH <i>Home</i>		8. CAUSE OF DEATH <i>Heart Disease</i>	
9. DISEASE OR INJURY <i>Myocardial Infarction</i>		10. MANNER OF DEATH <i>Natural</i>	
11. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		12. SIGNATURE OF REGISTRAR <i>John Doe</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>	
15. SIGNATURE OF WITNESS <i>John Doe</i>		16. SIGNATURE OF WITNESS <i>John Doe</i>	
17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	
21. SIGNATURE OF WITNESS <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>John Doe</i>	
23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>	
27. SIGNATURE OF WITNESS <i>John Doe</i>		28. SIGNATURE OF WITNESS <i>John Doe</i>	
29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>	
33. SIGNATURE OF WITNESS <i>John Doe</i>		34. SIGNATURE OF WITNESS <i>John Doe</i>	
35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>	
39. SIGNATURE OF WITNESS <i>John Doe</i>		40. SIGNATURE OF WITNESS <i>John Doe</i>	
41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>	
43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>	
45. SIGNATURE OF WITNESS <i>John Doe</i>		46. SIGNATURE OF WITNESS <i>John Doe</i>	
47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>	
51. SIGNATURE OF WITNESS <i>John Doe</i>		52. SIGNATURE OF WITNESS <i>John Doe</i>	
53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>	
55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>	
57. SIGNATURE OF WITNESS <i>John Doe</i>		58. SIGNATURE OF WITNESS <i>John Doe</i>	
59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>	
63. SIGNATURE OF WITNESS <i>John Doe</i>		64. SIGNATURE OF WITNESS <i>John Doe</i>	
65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>	
67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>	
69. SIGNATURE OF WITNESS <i>John Doe</i>		70. SIGNATURE OF WITNESS <i>John Doe</i>	
71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>	
75. SIGNATURE OF WITNESS <i>John Doe</i>		76. SIGNATURE OF WITNESS <i>John Doe</i>	
77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>	
79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>	
81. SIGNATURE OF WITNESS <i>John Doe</i>		82. SIGNATURE OF WITNESS <i>John Doe</i>	
83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>	
87. SIGNATURE OF WITNESS <i>John Doe</i>		88. SIGNATURE OF WITNESS <i>John Doe</i>	
89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>	
93. SIGNATURE OF WITNESS <i>John Doe</i>		94. SIGNATURE OF WITNESS <i>John Doe</i>	
95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>	
99. SIGNATURE OF WITNESS <i>John Doe</i>		100. SIGNATURE OF WITNESS <i>John Doe</i>	

RECEIVED
OCT 25 1957
BUREAU V. S.

10728

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAVRE DE GRACE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAVRE DE GRACE MD			
c. LENGTH OF STAY IN 1b 10 YRS				d. STREET ADDRESS RD #2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RD #2				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle M. Last DE BONIS				4. DATE OF DEATH Month Oct Day 7 Year 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 1, 1888 69 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK DE BONIS				14. MOTHER'S MAIDEN NAME ELIZABETH YAK.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT PEARL H. DE BONIS, HAVRE DE GRACE, RD #2 Address RD #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) NO						INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/11, 1957 , to 10/17, 1957 , that I last saw the deceased alive on 10/11, 1957 , and that death occurred at 8:55 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE F. J. Hatem M.D.				ADDRESS (Street, city or town, state) Aberdeen, MD		DATE SIGNED 10/18/57	
PHYSICIAN'S NAME (Type) F. J. Hatem				ADDRESS Aberdeen, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT. 11, 1957		22c. NAME OF CEMETERY OR CREMATORY BEL AIR MEMORIAL GARDENS		22d. LOCATION (City, town, or county) (State) BEL AIR, MD	
23. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell ADDRESS Havre de Grace, Md				24a. REC'D BY REGISTRAR DATE 10-11-57		24b. REGISTRAR'S SIGNATURE A. L. Lewis M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

701 14 1957

RECEIVED

10698

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 722 GREEN ST.		d. STREET ADDRESS 722 GREEN ST	
3. NAME OF DECEASED (Type or print) First Middle Last CARROLL WATTS DENNIS		4. DATE OF DEATH Month Day Year OCT 31 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 26 1882
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	11. BIRTHPLACE (State or foreign country) MD
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME DENNIS	
14. MOTHER'S MAIDEN NAME ALICE MITCHELL		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. ANNA ARMSTRONG HAVRE DE GRACE MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema. 420.0 DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Severe Metabolic			INTERVAL BETWEEN ONSET AND DEATH 1 hr gr-
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 10/24 , 19 57 , to OCT 31 , 19 57 , that I last saw the deceased alive on 10/24 , 19 57 , and that death occurred at 3:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE F. J. Hatem		ADDRESS (Street, city or town, state) DATE SIGNED 17 N. H. La. Rd. Aberdeen Md. 11/1/57	
PHYSICIAN'S NAME (Type) F. J. Hatem		Aberdeen - Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Nov. 3, 1957	22c. NAME OF CEMETERY OR CREMATORY ROCK RUN	22d. LOCATION (City, town, or county) (State) HARFORD MD
23. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell		ADDRESS Havre de Grace, Md.	
24a. REC'D BY REGISTRAR DATE 11-4-57		24b. REGISTRAR'S SIGNATURE A. L. Lewis M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF BURIAL OFFICIAL	
16. SIGNATURE OF FUNERAL HOME		17. SIGNATURE OF CHURCH OFFICIAL		18. SIGNATURE OF OTHER OFFICIALS	
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NOV 5 1957
BUREAU V. S.

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NOV 5 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10729 CERTIFICATE OF DEATH

10702

Reg. Dist. No. 180

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Belcamp Rural				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Belcamp			
c. LENGTH OF STAY IN TB Lifetime				d. STREET ADDRESS Harford Furnace			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Charles Edward Dickson				4. DATE OF DEATH Month Day Year Oct. 8, 1957			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 25, 1871		9. AGE (In years last birthday) 86 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Dickson				14. MOTHER'S MAIDEN NAME Nancy Kerr			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Robert Dickson,		Address Bel Air R.D., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Artery - Sunday metabolism							INTERVAL BETWEEN ONSET AND DEATH 2 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 42 , to OCT , 19 57 , that I last saw the deceased alive on OCT 7 , 19 57 , and that death occurred at 6 P. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE J. Ralph Harky M.D.				ADDRESS (Street, city or town, state) Churchville Maryland		DATE SIGNED OCT 10	
PHYSICIAN'S NAME (Type) J. Ralph Harky							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 11, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Francis		22d. LOCATION (City, town, or county) (State) Abingdon, Harford, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard R. Williams				24a. REC'D BY REGISTRAR DATE Oct. 11, 1957		24b. REGISTRAR'S SIGNATURE Norma B. Moore	

BUREAU V. S.

OCT 14 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10703

Reg. Dist. No. 180

10730

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Joppa</u>		c. LENGTH OF STAY IN 1b <u>2 yrs.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x1 Rural - Joppa</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Reckord Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles M. Diven</u>		4. DATE OF DEATH Month Day Year <u>October 24, 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 1, 1884</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Blacksmithing</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas H. Diven</u>		14. MOTHER'S MAIDEN NAME <u>A. Mary Resh</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT Address <u>Mrs. Andrew Mazer, Joppa, Md. R.D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>443x Congestive heart failure</u> DUE TO (b) <u>Cerebral thrombosis (3rd)</u> DUE TO (c) <u>Hypertensive Cardiovas. Dis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 day.</u> <u>12 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/1/53</u> , 19 <u>53</u> , to <u>10/24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/23</u> , 19 <u>57</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clifford F. Hudson</u> M.D.		ADDRESS (Street, city or town, state) <u>Fork, Md.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON, FORK, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 27 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Rock P. R.D.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul Hartenstein</u> ADDRESS <u>New Freedom, Md.</u>		24a. REC'D BY REGISTRAR <u>1</u> DATE <u>1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>Norma Moore</u>	

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BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

10704

10731

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		STATE <u>MD</u> COUNTY <u>HARFORD</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>High Point Road</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>High Point Road</u>	
TOWN <u>High Point Road</u>		LENGTH OF STAY (in this place) <u>9 yrs</u>		STREET ADDRESS <u>Forest Hill Rd</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>LESSIE JANE DUNCAN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 19 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>70014 1896</u>	9. AGE last birthday <u>61</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>9</u>		IF UNDER 24 HRS. Hours <u>9</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MO. M.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Calvin Cheek</u>				14. MOTHER'S MAIDEN NAME <u>Ennice Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-32-9685</u>		17. INFORMANT & ADDRESS <u>Franklin M Duncan Forest Hill Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) <u>PULMONARY EDEMA</u>						INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CONGESTIVE HEART FAILURE</u>						<u>OVER 1 YR</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u>						<u>OVER 1 YR</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/> While at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>MAX</u> , 19 <u>57</u> , to <u>OCT 19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>OCT 13</u> , 19 <u>57</u> , and that death occurred at <u>3:40 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Philip W. Hausman M.D.</u>		ADDRESS (Street, city, town, state) <u>307 HICKORY BEL AIR, Md</u>		DATE SIGNED <u>OCT 19, 1957</u>			
23. BURIAL, CREMATION REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>OCT 22 57</u>		NAME OF CEMETERY OR CREMATORY <u>Bell Air Mem. Gardens Bel Air Md</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <u>Priscilla Fournier</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Martin E. Kutz</u>		ADDRESS <u>Janet Kutz</u>	
DATE <u>10-22-57</u>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. MARRIAGE

6. OCCUPATION

7. DATE OF BIRTH

8. PLACE OF BIRTH

9. DATE OF DEATH

10. CAUSE OF DEATH

11. SEX

12. AGE

13. MARRIAGE

14. OCCUPATION

15. DATE OF BIRTH

16. PLACE OF BIRTH

17. DATE OF DEATH

18. CAUSE OF DEATH

19. SEX

20. AGE

21. MARRIAGE

22. OCCUPATION

23. DATE OF BIRTH

24. PLACE OF BIRTH

25. DATE OF DEATH

26. CAUSE OF DEATH

27. SEX

28. AGE

29. MARRIAGE

30. OCCUPATION

31. DATE OF BIRTH

32. PLACE OF BIRTH

33. DATE OF DEATH

34. CAUSE OF DEATH

35. SEX

36. AGE

37. MARRIAGE

38. OCCUPATION

39. DATE OF BIRTH

40. PLACE OF BIRTH

41. DATE OF DEATH

42. CAUSE OF DEATH

43. SEX

44. AGE

45. MARRIAGE

46. OCCUPATION

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49. DATE OF DEATH

50. CAUSE OF DEATH

51. SEX

52. AGE

53. MARRIAGE

54. OCCUPATION

55. DATE OF BIRTH

56. PLACE OF BIRTH

57. DATE OF DEATH

58. CAUSE OF DEATH

59. SEX

60. AGE

61. MARRIAGE

62. OCCUPATION

63. DATE OF BIRTH

64. PLACE OF BIRTH

65. DATE OF DEATH

66. CAUSE OF DEATH

67. SEX

68. AGE

69. MARRIAGE

70. OCCUPATION

71. DATE OF BIRTH

72. PLACE OF BIRTH

73. DATE OF DEATH

74. CAUSE OF DEATH

75. SEX

76. AGE

77. MARRIAGE

78. OCCUPATION

79. DATE OF BIRTH

80. PLACE OF BIRTH

81. DATE OF DEATH

82. CAUSE OF DEATH

83. SEX

84. AGE

85. MARRIAGE

86. OCCUPATION

87. DATE OF BIRTH

88. PLACE OF BIRTH

89. DATE OF DEATH

90. CAUSE OF DEATH

91. SEX

92. AGE

93. MARRIAGE

94. OCCUPATION

95. DATE OF BIRTH

96. PLACE OF BIRTH

97. DATE OF DEATH

98. CAUSE OF DEATH

99. SEX

100. AGE

101. MARRIAGE

102. OCCUPATION

BUREAU V. S.

OCT 24 1957

RECEIVED

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10699 CERTIFICATE OF DEATH

10705

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Harford Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAUR DE GRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RISING SUN</u>			
c. LENGTH OF STAY IN 1b <u>13 HRS 23 MIN</u>				d. STREET ADDRESS <u>07 X O. 2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Edwin</u> Last <u>ECCLES</u>				4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCTOBER 25, 1957</u>	
9. AGE (In years last birthday) yrs. <u>13</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>ROBERT WILLIAM ECCLES</u>			
14. MOTHER'S MAIDEN NAME <u>BEATRICE DALEY</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity - Tox.</u> DUE TO <u>776X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10/25, 1957</u> to <u>10/25, 1957</u> , that I last saw the deceased alive on <u>10/25, 1957</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Neil Taylor</u> M.D.				ADDRESS (Street, city or town, state) <u>Rising Sun, Md.</u> DATE SIGNED <u>10/25/57</u>			
PHYSICIAN'S NAME (Type) <u>Neil Taylor Jr.</u>				ADDRESS <u>Rising Sun - Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>10-25-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HARFORD MEMORIAL HOSPITAL</u>		22d. LOCATION (City, town, or county) (State) <u>Haure de Grace, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry A. Ziegler Administrator</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DATE 11-1-57</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Kewin M.D.</u>	

2071234XV2

CERTIFICATE OF DEATH

FIRST NAME LAST NAME SEX AGE DATE OF BIRTH PLACE OF BIRTH OCCUPATION MARITAL STATUS EDUCATION RELIGION RACE COLOR SEX AGE DATE OF BIRTH PLACE OF BIRTH OCCUPATION MARITAL STATUS EDUCATION RELIGION RACE COLOR		DECEASED DATE OF DEATH PLACE OF DEATH CAUSE OF DEATH MANNER OF DEATH MEDICAL HISTORY PREVIOUS ILLNESS PREVIOUS SURGERY PREVIOUS TRAUMA PREVIOUS DRUGS PREVIOUS ALCOHOL PREVIOUS TOBACCO PREVIOUS OTHER	
SIGNATURE OF DECEASED SIGNATURE OF WITNESS SIGNATURE OF PHYSICIAN SIGNATURE OF CLERK SIGNATURE OF JUDGE SIGNATURE OF SHERIFF SIGNATURE OF CORONER SIGNATURE OF DISTRICT ATTORNEY SIGNATURE OF COUNTY CLERK SIGNATURE OF STATE CLERK SIGNATURE OF SECRETARY OF HEALTH SIGNATURE OF COMMISSIONER OF HEALTH SIGNATURE OF GOVERNOR		CERTIFICATE OF DEATH DATE OF DEATH PLACE OF DEATH CAUSE OF DEATH MANNER OF DEATH MEDICAL HISTORY PREVIOUS ILLNESS PREVIOUS SURGERY PREVIOUS TRAUMA PREVIOUS DRUGS PREVIOUS ALCOHOL PREVIOUS TOBACCO PREVIOUS OTHER	

BUREAU V. B.

NOV 4 1957

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10700 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10706
10700 CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford-de-Grace</u>				c. LENGTH OF STAY IN 1b <u>1 Day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Hannah</u> Middle <u>Ellen</u> Last <u>Overitt</u>				4. DATE OF DEATH Month <u>10</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 5 / 1888</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Iris George</u>				14. MOTHER'S MAIDEN NAME <u>Estelle Patterson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT <u>WMP Everett Bel Air Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis Generalized</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>3 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>URINARY INCONTINENCE, TUMOUR OF U. BLADDER</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>53</u> to <u>Oct 6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 6th</u> , 19 <u>57</u> , and that death occurred at <u>3:50 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. Sandeeke M.D.</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 8 / 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Mary's Episcopal</u>		22d. LOCATION (City, town, or county) (State) <u>EMMERTON HARTFORD MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph T. Fales Bel Air Md</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 9 1957</u>		24b. REGISTRAR'S SIGNATURE <u>M. L. Lewis</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

DATE OF DEATH

MARYLAND

DATE OF DEATH

PLACE OF DEATH

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OCT 9 1957

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10707 185

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) p. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Bruce</u>		c. LENGTH OF STAY IN 1b <u>Port Deposit 07x2.2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Mem. Hosp.</u>		d. STREET ADDRESS <u>Port Deposit 07x2.2</u>	
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>Albino</u> Last <u>Ewing</u>		4. DATE OF DEATH Month <u>October</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-9-02</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Crippled</u>	11. BIRTHPLACE (State or foreign country) <u>Penn.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Edward Elie Ewing</u>	
14. MOTHER'S MAIDEN NAME <u>Hena May Gibson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>070</u>		17. INFORMANT <u>Mrs. Ruth Martin</u> Address <u>Port Deposit Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes Mellitus - uncontrolled.</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>4 yrs.</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 14</u> , 19 <u>57</u> to <u>Oct 17</u> , 19 <u>57</u> that I last saw the deceased alive on <u>Oct. 17</u> , 19 <u>57</u> , and that death occurred at <u>1:00 p.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Neil Taylor</u> M.D.		ADDRESS (Street, city or town, state) <u>Rising Sun, Md</u> DATE SIGNED <u>10/18/57</u>	
PHYSICIAN'S NAME (Type) <u>Neil Taylor Jr</u>		<u>Rising Sun, Md</u> <u>10/18/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct 20/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Rising Sun, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Earl Tyson</u> ADDRESS <u>Rising Sun, Md</u>		24a. REC'D BY REGISTRAR <u>DATE</u>	24b. REGISTRAR'S SIGNATURE <u>Dr. L. Lewis</u>

CERTIFICATE OF DEATH

Reg. No. 100

BUREAU V. 3

OCT 21 1957

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10702 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10708

Reg. Dist. No. 185

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>	
c. LENGTH OF STAY IN 1b <u>20 yrs.</u>		d. STREET ADDRESS <u>815 Erie</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Chester</u> <u>Faltynowicz</u>		4. DATE OF DEATH <u>October 19</u> 19 <u>57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/20/1917</u>
9. AGE (In years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>APL</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Faltynowicz</u>		14. MOTHER'S MAIDEN NAME <u>Josephine ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>W.W. 2</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mrs. Theresa Faltynowicz</u>		Address <u>Repair + Elizabeth St. Harre de Grace Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Poisoning by Carbon Monoxide</u> 9773.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Piped onto exhaust fumes into his car</u>	
20c. TIME OF INJURY Month, Day, Year <u>10-19-57</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>9 Navy</u>	20f. (City or town) <u>Harre de Grace</u> (County) <u>Harford</u> (State) <u>md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel An</u> DATE SIGNED <u>10-19-57</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>md</u>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/22/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>	22d. LOCATION (City, town, or county) (State) <u>Harre de Grace Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Benjamin S. Harre de Grace Md</u>		24a. REC'D BY REGISTRAR <u>A.L. Lewis M.D.</u> DATE <u>10-24-57</u>	
24b. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

BUREAU V. 3

OCT 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10703

CERTIFICATE OF DEATH

1070365

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>PENNSYLVANIA</u> b. COUNTY <u>Lancaster</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PEACH BOTTOM</u>			
c. LENGTH OF STAY IN 1b <u>2 HRS.</u>				d. STREET ADDRESS <u>75X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JERRY</u> Middle <u>WAYNE</u> Last <u>FLORA</u>				4. DATE OF DEATH Month <u>October</u> Day <u>30</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-22-1953</u>	
9. AGE (In years last birthday) <u>2</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Lancaster Penn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>David Franklin Flora</u>				14. MOTHER'S MAIDEN NAME <u>MAXINE GENEVA HAMILTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>David F. Flora</u> Address <u>Peachbottom, Penn.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tracheobronchitis</u> <u>501x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>7 hours</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10/29</u> , 19 <u>57</u> to <u>10/30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1 AM 10/30 1957</u> , and that death occurred at <u>11:45</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>Neil Taylor Jr.</u> M.D. <u>Rising Sun</u> ADDRESS (Street, city or town, state) <u>Rising Sun Maryland</u> DATE SIGNED <u>10/31/57</u> PHYSICIAN'S NAME (Type) <u>Neil Taylor Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Nov 3 1957</u>		<u>Benn Hill Cem</u>		<u>Quarryville Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Earl Tyson</u> ADDRESS <u>Rising Sun Md</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Dr. H. L. Lewis</u>	

NOV 4 1957

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
MARRIAGE		EDUCATION		OCCUPATION		RELIGION		MANNER OF DEATH		CAUSE OF DEATH	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TEMPERATURE		PULSE		RESPIRATION	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL	

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NOV 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10710

Reg. Dist. No.

10732

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryman</u>	c. LENGTH OF STAY IN 1b <u>8 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryman</u> X2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Witherspoon's Trailer Park</u>	
3. NAME OF DECEASED (Type or print) <u>W. H. A. M. E. Foreman</u>		4. DATE OF DEATH Month <u>October</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/7/1943</u>
9. AGE (In years last birthday) <u>14</u> yrs.		IF UNDER 1 YEAR Months <u>14</u> Days <u>14</u>	IF UNDER 24 HRS. Hours <u>14</u> Min. <u>14</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<u>Student</u>		<u>School</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USC</u>	
13. FATHER'S NAME <u>Albert C. Foreman</u>		14. MOTHER'S MAIDEN NAME <u>Lillian M. Harmer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<input type="checkbox"/>		<input type="checkbox"/>	
17. INFORMANT		Address	
<input type="checkbox"/>		<input type="checkbox"/>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>G.S.W. R. Chest</u> <u>919.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>919.0</u> DUE TO (c) <u>919.0</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Accidentally shot with shot-gun</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Accidentally shot with shot-gun</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>5</u> p. m. <u>10-7-57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Perryman</u> <u>Hartford</u> <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>MA</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>10-8-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/11/1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air</u> <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Harrington</u>		24a. REC'D BY REGISTRAR <u>11-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Hellie R. Perry</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

OCT 14 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10711

Reg. Dist. No. 183

10704

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrods Creek</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3401-4	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>For Holabird</u>	
4. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Doa Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harry E Gardner</u>		4. DATE OF DEATH <u>October 20</u> 1957	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/19/1925</u>
9. AGE (In years last birthday) <u>32</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>soldier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>USA</u>	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Elara (Unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>current</u>		16. SOCIAL SECURITY NO. <u>145-18-0663</u>	
17. INFORMANT <u>Quartermaster 7pt. APG. 2nd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, auto - auto type</u>	
20c. TIME OF INJURY Month, Day, Year <u>12-20-57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>US Route 40</u>		20f. (City or town) (County) (State) <u>Edgewood Harford Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald P. Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md.</u> DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gerald P. Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10-20-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>10/22/1957</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Franklin New Jersey</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Carving Aberdeen Md.</u>		24a. REC'D BY REGISTRAR <u>10-24-57</u> 24b. REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NEW YORK STATE
DEPARTMENT OF HEALTH

BUREAU V. S.

OCT 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10712

10705

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Havre de Grace</u>	
c. LENGTH OF STAY IN 1b <u>LIFE</u>		d. STREET ADDRESS <u>1603 N. Stokes</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOT Harford Memorial Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ronald Spencer Grieninge</u>		4. DATE OF DEATH <u>October 9 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-18-39</u>
9. AGE (In years last birthday) <u>18</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDING</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lyell Ed. Grieninge</u>		14. MOTHER'S MAIDEN NAME <u>MILDRED STEINER ELLIOTT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u>217-364733</u>	
17. INFORMANT <u>Lyell E. Grieninge</u>		Address <u>Havre de Grace, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull, compound</u> 816x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture R leg.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Air to vacuum, auto-object type</u>	
20c. TIME OF INJURY Month, Day, Year <u>10-9-57</u> Hour <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>155 + 0 Ave. Havre de Grace - MD</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C. Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air MD</u> DATE SIGNED <u>10-9-57</u>	
EXAMINER'S NAME (Type) <u>Gerald C. Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 13, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>HAVRE DE GRACE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>		24a. REC'D BY REGISTRAR <u>10-14-57</u>	
ADDRESS <u>HAVRE DE GRACE, MD</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [illegible] SEX: [illegible] AGE: [illegible] RACE: [illegible]
 DATE OF BIRTH: [illegible] PLACE OF BIRTH: [illegible]
 OCCUPATION: [illegible] MARITAL STATUS: [illegible]
 PRESENT ADDRESS: [illegible]
 CAUSE OF DEATH: [illegible]
 MANNER OF DEATH: [illegible]
 SIGNATURE OF EXAMINER: [illegible]
 DATE: [illegible]

BUREAU V. S.

OCT 15 1957

RECEIVED

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10713

10706

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 FilmG222 10-29-57 et

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>XO XXXXXXXXXX RD. 2 Bel Air</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>DOA Annapolis Naval Hospital</i>		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) <i>CL, SS and Franklin Hash</i>		4. DATE OF DEATH <i>October 18 19 57</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-19-39</i>
9. AGE (In years last birthday) <i>18</i> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Building & Construction</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Glenn Hash</i>		14. MOTHER'S MAIDEN NAME <i>Mary Long</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>Glenn Hash</i>	
17. INFORMANT <i>Glenn Hash</i>		Address <i>R.D. 2 Bel Air, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture skull comminuted, compound.</i> 819X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fracture both bones L. leg</i>			INTERVAL BETWEEN ONSET AND DEATH <i>—</i>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto accident, auto-object type</i>
20c. TIME OF INJURY Month, Day, Year <i>3 10-18 19 57</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Brush X</i>	20f. (City or town) <i>Pylesville Harford Md</i> (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Gerald C Palmer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Gerald C Palmer MD</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/21/57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Welcome Home Cemetery</i>		22d. LOCATION (City, town, or county) <i>R.D. Bel Air Md.</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Farring</i>		24a. REC'D BY REGISTRAR <i>10-24-57</i> 24b. REGISTRAR'S SIGNATURE <i>A.L. Lewis M.D.</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10714

10733

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Magnolia				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Magnolia			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle G. Last Hueitt				4. DATE OF DEATH Month Oct. Day 10, Year 19 57			
5. SEX male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 26, 1891		9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elisha Hueitt				14. MOTHER'S MAIDEN NAME Hannah Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ?		17. INFORMANT Samule K. Hueitt, Joppa R.D., Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Possible nephritis						INTERVAL BETWEEN ONSET AND DEATH several hrs. many years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 11, 19 56 , to October 10, 19 57 , that I last saw the deceased alive on October 1, 19 57 , and that death occurred at 3:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 115 Fulford Ave. DATE SIGNED 10/12/57							
ACTUAL SIGNATURE Paul S. Stonesifer, Jr. M.D.				DATE SIGNED 10/12/57			
PHYSICIAN'S NAME (Type) Paul S. Stonesifer, Jr.				Bel Air, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 14, 1957		22c. NAME OF CEMETERY OR CREMATORY Chestnut Grove		22d. LOCATION (City, town, or county) (State) Rocks, Harford, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard McLennox Jr.				ADDRESS Abingdon, Md.		24a. REC'D BY REGISTRAR Oct. 14, 1957	
				24b. REGISTRAR'S SIGNATURE Norma G. Moore			

BUREAU V. S.

OCT 16 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10707 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10715

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Aberdeen</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>#2 Buchanan Ave.</u>		d. STREET ADDRESS <u>12 Buchanan Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Arthur E Johnson</u>		4. DATE OF DEATH <u>October 10 1957</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>31 March 1880</u>	
9. AGE (in years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Holloway</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-09-9069</u>	
17. INFORMANT <u>Mrs. Arthur E. Johnson</u>		Address <u>2 Buchanan Ave. Aberdeen, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>420.1</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>-</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/13/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Spesutia</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen, R.D. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Garruey</u>		ADDRESS <u>Aberdeen, Md.</u>	
24a. REC'D BY REGISTRAR <u>Oct 13/57</u>		24b. REGISTRAR'S SIGNATURE <u>Hellie R. Perry</u>	

DATE SIGNED

10-11-57

STATE OF NEW YORK
 DEPARTMENT OF HEALTH
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

[Faint, mostly illegible text from the reverse side of the document is visible through the paper. Discernible words include:]

George Jackson
 31 West 11th St
 New York City
 1957

BUREAU V. 2

OCT 16 1957

RECEIVED

[Faint text and markings at the bottom right of the page, including:]

10/16/57
 10/16/57
 10/16/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10708

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10716

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				c. LENGTH OF STAY IN 1b 11 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First Edgar Middle Elgar Last King				4. DATE OF DEATH Month October Day 2 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 21, 1917		9. AGE (In years lost birthday) yrs. 40	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY US Army		11. BIRTHPLACE (State or foreign country) Oklahoma		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John King				14. MOTHER'S MAIDEN NAME Iva Heaton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 446-01-01379		17. INFORMANT Official Army Records, APGm Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable acute coronary artery occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. 11 p. m. Month, Day, Year 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 2, 1957 to October 2, 1957 , that I last saw the deceased alive on October 2, 1957 , and that death occurred at 1105a M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William M. Michener		ADDRESS (Street, city or town, state) US Army Hospital, Aberdeen Proving Ground, Md.					
PHYSICIAN'S NAME (Type) WILLIAM M MICHENER, Capt, MC		DATE SIGNED Oct 2, 1957					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 10/4/57		22c. NAME OF CEMETERY OR CREMATORY Kaufer		22d. LOCATION (City, town, or county) (State) Oxas	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Garrison Aberdeen Md.				24a. REC'D BY REGISTRAR Oct 4-57		24b. REGISTRAR'S SIGNATURE Nellie R Perry	

Figure 1. Study design.

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Journal of Management Education

2710-10-94

BUREAU V. 5

7 OCT. 7 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10709

CERTIFICATE OF DEATH

Reg. Dist. No.

185-

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission) a. STATE <u>Penn</u> b. COUNTY <u>LANCASTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERDE GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PEACH BOTTOM 75 x - 3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>		d. STREET ADDRESS <u>RFD</u>	
3. NAME OF DECEASED (Type or print) First <u>Nina</u> Middle <u>V.</u> Last <u>Knight</u>		4. DATE OF DEATH Month <u>October</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-27-1896</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Orr</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Sampson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>J. Graham Knight, Peach Bottom, Pa.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Thrombosis</u> <u>422.1</u> DUE TO <u>and hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2-3 hours.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sep. 29th, 1957</u> to <u>Oct. 2nd, 1957</u> that I last saw the deceased alive on <u>October 2, 1957</u> and that death occurred at <u>8:50 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward C. Foon</u> M.D.		ADDRESS (Street, city or town, state) <u>211 N. Union Ave.</u> DATE SIGNED <u>10/2/57</u>	
PHYSICIAN'S NAME (Type) <u>Edward C. Foon, M.D.</u>		<u>Haverde Grace, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-5-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Warlington</u>	22d. LOCATION (City, town, or county) (State) <u>Warlington, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. A. Patterson & Son, Perryville, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>10-3-57</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>	

BUREAU V. F.

OCT 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 5,6 FilmG222 11-4-57 et

CERTIFICATE OF DEATH

10710

Reg. Dist. No.

10718

1. PLACE OF DEATH o. COUNTY Habford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 626 Brenda Lane				d. STREET ADDRESS 626 Brenda Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Walter Middle W. Last Kollmar				4. DATE OF DEATH Month October Day 24 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 17 March 1919	
9. AGE (In years lost birthday) yrs. 38		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Analyst		11. BIRTHPLACE (State or foreign country) U.S. Gov't	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Analyst		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Walter H. Kollmar				14. MOTHER'S MAIDEN NAME Frieda Jungermann			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW 2, Korean, 145-03-4100			
17. INFORMANT Joshua Kramer				Address Aberdeen, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.1 Escherichia, abdominal DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 4 months						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from June 29, 1957 , to Oct 24, 1957 , that I last saw the deceased alive on Oct 24, 1957 , and that death occurred at 10:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 617 W. Bel Air Ave. Oct 25, 1957 DATE SIGNED _____ ACTUAL SIGNATURE B. J. Plunkett Jr. M.D. _____ PHYSICIAN'S NAME (Type) B. J. Plunkett Jr. M.D. Aberdeen, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				22b. DATE THEREOF 10/28/57		22c. NAME OF CEMETERY OR CREMATORY Greenmount	
22d. LOCATION (City, town, or county) Baltimore				(State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE John G. Koring				ADDRESS Aberdeen, Md.		24a. REC'D BY REGISTRAR DATE Oct 28/57	
24b. REGISTRAR'S SIGNATURE Nellie R. Perry							

Договор № _____

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PLPK 150

5702

Walter H. Hollman

1995

001-50-341, no 192, 2

BUREAU V. M.

OCT 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10719

10711

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>	c. LENGTH OF STAY IN 1b <i>24 yrs.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>31 Aberdeen</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>411 Edmund Street</i>		d. STREET ADDRESS <i>1411 Edmund St.</i>	
3. NAME OF DECEASED (Type or print) First <i>Joseph</i> Middle <i>E.</i> Last <i>Lawson</i>		4. DATE OF DEATH Month <i>10</i> Day <i>3</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-27-1897</i>
9. AGE (In years last birthday) <i>60</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Barber</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Barber</i>	
11. BIRTHPLACE (State or foreign country) <i>Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Charles Lawson</i>		14. MOTHER'S MAIDEN NAME <i>Isabell Lewis</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Mrs. Mary E. Lawson - Aberdeen Md.</i>		Address <i>411 Edmund St.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>177X</i> DUE TO <i>Inanition</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma of prostate</i> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <i>6 weeks</i> <i>5 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10-2</i> 19 <i>57</i> , to <i>10-3</i> 19 <i>57</i> , that I last saw the deceased alive on <i>10-2</i> 19 <i>57</i> , and that death occurred at <i>5:45</i> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Aberdeen, Md.</i> DATE SIGNED <i>10-4-57</i>			
ACTUAL SIGNATURE <i>B. J. Plunkett Jr.</i> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>10-8-1957</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Aberdeen Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Otelia B. Bullock - Harford Sussex Md.</i>		24a. REC'D BY REGISTRAR <i>Oct 5-57</i>	
24b. REGISTRAR'S SIGNATURE <i>Hettie R. Perry</i>			

BUREAU V. S.

OCT 7 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10712 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10720
Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Mch</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belt Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Detroit</u> 59X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in-hospital, give street address) <u>336 Catherine St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles Herbert Lovell</u>		4. DATE OF DEATH <u>October 4</u> 19 <u>57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 10, 1886</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF INDUSTRY <u>CONTROL</u>	
11. BIRTHPLACE (State or foreign country) <u>LONDON, ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH GARD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>S. EVERET LOVELL</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>—</u> (a), stating the underlying cause last. DUE TO (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>10-7-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT. 8, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>WOODMERE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>DETROIT, MICH.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Foster</u> ADDRESS <u>BROADWAY AND WILLIAMS STS. BELAIR, MD.</u>		24a. REC'D BY REGISTRAR <u>10-5-57</u>	
24b. REGISTRAR'S SIGNATURE <u>M. Ella Pinwood</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
OCT 9 1957
BUREAU V. S.

10734

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL</u>		LENGTH OF STAY (in this place) <u>14 WEEKS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAVRE DE GRACE,</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD CONVALESCENT HOME</u>				STREET ADDRESS (If rural give location) <u>224 N. STOKES ST.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>WALTER OSBORNE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>OCTOBER 7 1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WH</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>11/11/1884</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED CARPENTER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>UNK</u>	11. BIRTHPLACE (State or foreign country) <u>SWAN CREEK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William DAVIS OSBORN</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Mitchell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNK</u>		17. INFORMANT & ADDRESS <u>Virginia Wilson, Aberdeen Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <u>Lobar Pneumonia, bilateral, Atypical Hypostatic</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Terminating Cerebral thrombosis (Oct. 2, 1957)</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chr. Cardio-Vascular Disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Duodenal ulcer</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 23, 1957</u> , to <u>Oct. 7, 1957</u> , that I last saw the deceased alive on <u>Oct. 6, 1957</u> , and that death occurred at <u>11:40 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u> M.D. <u>Forest Hill</u>				ADDRESS (Street, city, town, state) <u>Maryland</u> DATE SIGNED <u>10-7-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>10/10/57</u>		NAME OF CEMETERY OR CREMATORY <u>PRESBYTERIAN,</u>		LOCATION (City, town, or county) (State) <u>Churchville Md</u>	
24. REC'D BY REGISTRAR DATE <u>10-9-57</u>		REGISTRAR'S SIGNATURE <u>Prueella Lowndes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Pennington + Low Harrod, Green M</u>			

INSTRUCTIONS

1
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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The below copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

Reg. Div. 116

1. PLACE OF BIRTH		2. SEX		3. RACE		4. DATE OF BIRTH		5. DATE OF DEATH		6. PLACE OF DEATH		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. MEDICAL EXAMINATION		10. SIGNATURE OF DECEASED		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF CLERK		14. SIGNATURE OF JUDGE		15. SIGNATURE OF SHERIFF		16. SIGNATURE OF CORONER		17. SIGNATURE OF JURY		18. SIGNATURE OF COURT		19. SIGNATURE OF STATE		20. SIGNATURE OF NATION			
[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]	

BUREAU Y. R.

OCT 11 1957

RECEIVED

NOTIFICATION
 DEPARTMENT OF HEALTH
 BALTIMORE, MARYLAND
 10-11-57

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10713

CERTIFICATE OF DEATH

Reg. Dist. No. 1072285-

1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY CECIL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE		c. LENGTH OF STAY IN 1b 6 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural 07x1.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) IRA First 5 Middle Poist Last				4. DATE OF DEATH Month OCTOBER Day 29 Year 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-18-1894		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY Owner		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George H. Poist				14. MOTHER'S MAIDEN NAME Emma a. Nickle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-24-2509		17. INFORMANT Frank S. Poist, Port Deposit, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis - 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. Nephritis -						INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs -	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 1956 to Oct 29 , 19 57 , that I last saw the deceased alive on Oct 29 , 19 57 , and that death occurred at 4:40 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Clarence I. Benson - M.D.				ADDRESS (Street, city or town, state) Port Deposit, Md.			
DATE SIGNED 10/30/57							
PHYSICIAN'S NAME (Type) Clarence I. Benson, M.D.				Port Deposit Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-31-1957		22c. NAME OF CEMETERY OR CREMATORY West Nottingham		22d. LOCATION (City, town, or county) (State) Colord, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE Lee a. Patterson & Son, Perryville, Md.				24a. REC'D BY REGISTRAR DATE 10-31-57		24b. REGISTRAR'S SIGNATURE G. L. Lewis M.D.	

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The best copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10723

CERTIFICATE OF DEATH

10714

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Maryland</u>		COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bel Air</u>		LENGTH OF STAY (in this place) <u>5 Years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bel Air</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Convalescent Home</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>Annie M. Purcell</u>				4. DATE OF DEATH (Month) <u>October</u> (Day) <u>10</u> (Year) <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>August 2, 1867</u>	9. AGE last birthday <u>90</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lawrence Purcell</u>				14. MOTHER'S MAIDEN NAME <u>Annie Riley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Dora Johnson, Bel Air, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
491x IMMEDIATE CAUSE (A) <u>Bronchial pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Upper respiratory infection</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/15</u> , 19 <u>50</u> , to <u>October 10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>October 9</u> , 19 <u>57</u> , and that death occurred at <u>10:05 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u> M.D.				DATE SIGNED <u>October 11, 1957</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>October 12 1957</u>		NAME OF CEMETERY OR CREMATORY <u>St. Ignatius</u>		LOCATION (City, town, or county) (State) <u>Hickory, Harf. Co., Md.</u>	
24. REC'D BY REGISTRAR DATE <u>10-11-57</u>		REGISTRAR'S SIGNATURE <u>Priscilla Lowwood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u> ADDRESS <u>Broadway & Williams Sts. BEL Air, Maryland</u>			

10715

CERTIFICATE OF DEATH

10724

Reg. Dist. No.

181

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Aberdeen</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>111 Balto Street</u>		d. STREET ADDRESS <u>1 111 Balto Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Grove</u> Middle <u>Watson</u> Last <u>Robson</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 5th 1882</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Emp. Carpenter</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Andrew Robson</u>		14. MOTHER'S MAIDEN NAME <u>Ella Bond</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-03-5530</u>	
17. INFORMANT <u>Allen B. Robson</u>		Address <u>Aberdeen Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inanition</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral thrombosis</u> DUE TO (c) <u>Cerebral & generalized arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>3 months</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr 8</u> , 1957, to <u>Oct 22</u> , 1957, that I last saw the deceased alive on <u>Oct 22</u> , 1957, and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. J. Plunkett Jr.</u>		ADDRESS (Street, city or town, state) <u>617 W. Belair Ave</u>	
PHYSICIAN'S NAME (Type) <u>B. J. Plunkett Jr. M.D.</u>		DATE SIGNED <u>10-23-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/24/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Seneca Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Stanley New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Darrow</u>		ADDRESS <u>Aberdeen Maryland</u>	
24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>Nellie R Perry</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

MASSACHUSETTS DEPARTMENT OF HEALTH—BOSTON

OCT 28 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The attending physician or hospital may retain a copy of the death certificate for the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10725

Item 21 Film 222 11-15-57 ams

CERTIFICATE OF DEATH

10716

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Hartford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bel Air</u>		LENGTH OF STAY (in this place) <u>54 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bel Air Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS <u>RD 1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Rebecca</u> (Middle) <u>G</u> (Last) <u>Ruff</u>				(Month) <u>Oct</u> (Day) <u>26</u> (Year) <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb 1875</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>King George Co Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>BEN. J. GRIMES</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>HENRY RUFF</u> <u>Bel Air RD 1</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
903.0 IMMEDIATE CAUSE (A) <u>CARDIO-RESP FAILURE</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 MIN.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>PULMONARY EDEMA</u>				<u>30 MIN</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>SHOCK IN 82 YR OLD CONGESTIVE</u>				<u>} 1 HOUR.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>FAILURE PATIENT FROM BROKEN HIP-AT</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) <u>Home</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Rural Bel Air</u> <u>Hartford</u> <u>Md.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Oct 26</u> <u>57 P.M.</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR? <u>Fell on bedroom floor - apparently tripped over rug.</u>			
22. I hereby certify that I attended the deceased from <u>1955</u> , to <u>26 OCT</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>26 OCT</u> , 19 <u>57</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. P. Andrew</u>				ADDRESS (Street, city, town, state) <u>Bel Air, Md.</u>		DATE SIGNED <u>28 OCT 57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Oct 29-57</u>		NAME OF CEMETERY OR CREMATORY <u>Walters Meeting House</u>		LOCATION (City, town, or county) (State) <u>THOMAS RUN RD Hartford MD</u>	
24. REC'D BY REGISTRAR DATE <u>10-28-57</u>		REGISTRAR'S SIGNATURE <u>Prueella Lowndes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Foster</u> ADDRESS <u>Bel Air Md</u>			

RECEIVED

FOR STATE
HEALTH DEPT.

10717

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10726

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Hartford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY in 1b <u>4 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Country Life Farm</u>			d. STREET ADDRESS <u>Country Life Farm</u>		
3. NAME OF DECEASED (Type or print) <u>Charles A</u>			4. DATE OF DEATH Month <u>October</u> Day <u>19</u> Year <u>1957</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 20, 1891</u>		9. AGE (In years last birthday) <u>65</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Commodore Merchant Service</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles Ryan</u>			14. MOTHER'S MAIDEN NAME <u>Agnes Sullivan</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Charles A. Ryan</u> Address <u>Marylander Apts</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Lung</u> <u>163x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH <u>-</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, md.</u>		DATE SIGNED <u>10-19-57</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>		23. FURNERAL DIRECTOR'S SIGNATURE <u>H. W. Mease & Son 805 N. Calvert St.</u>			
24a. REG'D BY REGISTRAR <u>DATE 21 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Forwood</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FURNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

BUREAU V. S.

OCT 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10727

10718

CERTIFICATE OF DEATH

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3 Vol 4 Darlington to Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>12 days</u>		d. STREET ADDRESS <u>Plaza 1005 - Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Florence P</u> Middle <u>Sadler</u> Last <u>Sadler</u>		4. DATE OF DEATH Month <u>October</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov-15-1869</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13. FATHER'S NAME <u>George T. Sadler</u>	
14. MOTHER'S MAIDEN NAME <u>Ann S. Platt</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Ann H. Wilson, Darlington, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rectal polyp</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Oct 7</u> , 1957, to <u>October 19</u> , 1957, that I last saw the deceased alive on <u>October 19</u> , 1957, and that death occurred at <u>2:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James McC. Finney</u>		ADDRESS (Street, city or town, state) <u>330 S. UNION AVE, Harford Grace, Md.</u>	
DATE SIGNED <u>Oct. 19, 1957</u>		PHYSICIAN'S NAME (Type) _____	
22a. BYRIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>10/21/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stewart Moore</u>		ADDRESS <u>100 York-Baltimore</u>	
24a. REC'D BY REGISTRAR <u>DATE 22 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. L. Lewis</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1957

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. CITY OF BIRTH</p>	
<p>7. STATE OF BIRTH</p>		<p>8. COUNTRY OF BIRTH</p>	
<p>9. OCCUPATION</p>		<p>10. CAUSE OF DEATH</p>	
<p>11. MANNER OF DEATH</p>		<p>12. PLACE OF DEATH</p>	
<p>13. DATE OF DEATH</p>		<p>14. TIME OF DEATH</p>	
<p>15. SIGNATURE OF DECEASED</p>		<p>16. SIGNATURE OF WITNESS</p>	
<p>17. SIGNATURE OF PHYSICIAN</p>		<p>18. SIGNATURE OF CLERK</p>	
<p>19. SIGNATURE OF REGISTRAR</p>		<p>20. SIGNATURE OF JUDGE</p>	

BUREAU V. S.

OCT 22 1957

RECEIVED

10719

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>7 HRS 55 MIN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHITEFORD X2</u>			
				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) <u>LAURA</u> First <u>BELLE SEYMOUR</u> Middle <u>LAST</u> Last				4. DATE OF DEATH <u>OCTOBER 7 1957</u> Month Day Year			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 13, 1887</u>	
				9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>WILLIAM REED</u>				14. MOTHER'S MAIDEN NAME <u>LETTIE DOLLY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>ELSIE HARDING</u> Address <u>STREET, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Sclerosis</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>10/6</u> , 19 <u>57</u> , to <u>10/7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/7</u> , 19 <u>57</u> , and that death occurred at <u>7:55 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Neil Taylor</u>				ADDRESS (Street, city or town, state) <u>Rising Sun, Md</u>			
PHYSICIAN'S NAME (Type) <u>Neil Taylor Jr</u>				DATE SIGNED <u>10/8/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-9-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SLATE RIDGE</u>		22d. LOCATION (City, town, or county) (State) <u>DELTA, PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkins</u>				ADDRESS <u>Delta, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>10-9-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>A. L. Hewitt M.D.</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OCT 10 1957

RECEIVED

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

10720

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Edgewood</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD Memorial Hospital</u>				d. STREET ADDRESS <u>Bell 118</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anthony</u> Middle <u>Estes</u> Last <u>SILVEIRA</u>				4. DATE OF DEATH Month <u>October</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 31, 1897</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Business Manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Partugal</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Silveira, Anthony A.</u>				14. MOTHER'S MAIDEN NAME <u>Francisca da Gloria Vargas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-20-7893</u>		17. INFORMANT <u>Georgia I. Silveira</u> Address <u>Edgewood, Maryland.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 11th, 1957</u> to <u>Oct. 21, 1957</u> , that I last saw the deceased alive on <u>Oct. 21st, 1957</u> , and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward C. Loo, M.D.</u>				ADDRESS (Street, city or town, state) <u>211 N. Union Ave. Harford, Md.</u> DATE SIGNED <u>10/22/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 24, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air, Harford, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward C. Loo, Jr.</u> ADDRESS <u>Abingdon, Md.</u>				24a. REC'D BY REGISTRAR <u>Oct 28 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Jr. A. L. Lewis</u>	

RECEIVED

10735

CERTIFICATE OF DEATH

10730

Reg. Dist. No. 1802

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Madonna</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Madonna x2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) <u>NELSON-G-SMITH</u> First Middle Last				4. DATE OF DEATH <u>Oct 21st</u> 19 <u>57</u> Month Day Year			
5. SEX <u>M-</u>	6. COLOR OR RACE <u>Negro-</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 13-1884</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Belhel Church</u>		11. BIRTHPLACE (State or foreign country) <u>Cockeysville Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Ignatius G Smith</u>				14. MOTHER'S MAIDEN NAME <u>Laura Tittle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>not</u>		16. SOCIAL SECURITY NO. <u>212-32-0985A</u>		17. INFORMANT <u>David V. Smith</u>		Address <u>White Hall Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS, Acute.</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ARTERIOSCLEROTIC - Hypertensive HT. Disease</u> (c) <u>CORONARY Sclerosis -</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 HR's.</u> <u>10 years.</u> <u>10 years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8/17/1954</u> to <u>10/16/1957</u> , that I last saw the deceased alive on <u>10/14/1957</u> , and that death occurred at <u>6:40 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. James Thomison Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Jarrettsville, Md</u> DATE SIGNED <u>10/23/57</u>			
PHYSICIAN'S NAME (Type) <u>S. JAMES THOMISON, Jr., M. D. Jarrettsville, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 24-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Trinity</u>		22d. LOCATION (City, town, or county) (State) <u>Trinity Jarrettsville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. S. Keith</u> ADDRESS <u>Jarrettsville, Md</u>				24a. REC'D BY REGISTRAR <u>10-26-57</u>		24b. REGISTRAR'S SIGNATURE <u>Perilla Souwood</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
PLACE OF BIRTH		CITY		STATE		COUNTRY	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH	
PLACE OF DEATH		CITY		STATE		COUNTRY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

RECEIVED
OCT 29 1957
BUREAU V. 1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10721

CERTIFICATE OF DEATH

10731
Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <u>HARford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE de GRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u> 07X22			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>HARford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>Box 214</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Norman Tracy Stecher</u>				4. DATE OF DEATH Month Day Year <u>October 31 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 21, 1956</u>	
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Norman Tracy Stecher</u>		14. MOTHER'S MAIDEN NAME <u>VIVIAN BURGER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Norman J. Stecher, Perryville, Md. R.F.W.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tracheo Bronchitis</u> <u>501x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Virus Pneumonia</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>48 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>492x</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF DEATH Hour a. m. p. m. Month, Day, Year 19 <u>19</u>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct 24</u> , 19 <u>57</u> , to <u>Oct 31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 31</u> , 19 <u>57</u> , and that death occurred at <u>6:35 p. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>11-1-57</u>			
PHYSICIAN'S NAME (Type) <u>G. H. Richards, Jr.</u>				ADDRESS (Street, city or town, state) <u>Port Deposit - Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11-3-1957</u>		<u>Hofuwell cemetery</u>		<u>Port Deposit, Md. Rural</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. A. Patterson & Son, Perryville, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 11-1-57</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Hewitt Md.</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10732

CERTIFICATE OF DEATH

10736

Reg. Dist. No. 182

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The attending physician or hospital may be retained by the attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rocks</u>		LENGTH OF STAY (in this place) <u>5</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rocks</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Mary Josephine Sweeting</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>October 17, 19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 3, 1869</u>	9. AGE last birthday <u>88</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>14</u>		IF UNDER 24 HRS. Hours <u>14</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Cherry Hill Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin Rigdon</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Rigdon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Mary Bosley Rocks Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>						<u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u>						<u>Approx. 20 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Deafness</u>						<u>Unknown.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 19, 19 52</u> , to <u>Oct. 17, 19 57</u> , that I last saw the deceased alive on <u>Oct. 15, 19 57</u> , and that death occurred at <u>7 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Robert Barthel</u>		M.D.		ADDRESS (Street, city, town, state) <u>Forest Hill, Maryland</u>		DATE SIGNED <u>10-17-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct 19-57</u>		NAME OF CEMETERY OR CREMATORY <u>EMORY church</u>		LOCATION (City, town, or county) (State) <u>Emory, Harford, Md</u>	
24. REC'D BY REGISTRAR DATE <u>10-21-57</u>		REGISTRAR'S SIGNATURE <u>Priscilla Lowndes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Martin Smith Janet Williams</u>			

VS AISC 1-55 10M

CERTIFICATE OF DEATH

1. DECEASED PERSON'S NAME

2. SEX ☐ MALE ☐ FEMALE

3. AGE

4. PLACE OF BIRTH

5. DATE OF BIRTH

6. OCCUPATION

7. MARITAL STATUS

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. DATE OF DEATH

11. TIME OF DEATH

12. PLACE OF DEATH

13. SIGNATURE OF DECEASED

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF PHYSICIAN

16. SIGNATURE OF REGISTRAR

17. SIGNATURE OF CLERK

18. SIGNATURE OF JURY

19. SIGNATURE OF JUDGE

20. SIGNATURE OF SHERIFF

21. SIGNATURE OF CORONER

BUREAU V. 2

OCT 23 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

10737

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barlingtton Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barlingtton Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Leonard</u> First <u>Thompson</u> Middle <u>Thompson</u> Last		4. DATE OF DEATH <u>Oct 5</u> Month <u>Oct</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15, 1903</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grayson Co, Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>V. S. A.</u>		12. CITIZEN OF WHAT COUNTRY <u>V. S. A.</u>	
13. FATHER'S NAME <u>Geo Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Frame</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes-no, or shown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-18-1012</u>	
17. INFORMANT <u>Mrs Leonard Thompson</u>		Address <u>Barlingtton Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic C-V Disease</u> DUE TO (c) <u>7 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>57</u> , to <u>Oct</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 5</u> , 19 <u>57</u> , and that death occurred at <u>1 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Ralph Herky</u> M.D.		ADDRESS (Street, city or town, state) <u>Churchville Md</u> DATE SIGNED <u>Oct 18</u>	
PHYSICIAN'S NAME (Type) <u>J. Ralph Herky MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Oct. 10, 1957</u>		22b. DATE THEREOF <u>Oct. 10, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bel-Air Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>		ADDRESS <u>Barlingtton Md.</u> 24a. REC'D BY REGISTRAR <u>C. H. Kirk</u> 24b. REGISTRAR'S SIGNATURE <u>C. H. Kirk</u> DATE <u>Oct. 9, 1957</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore, Md.

BUREAU V. H.

JUL 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10734

Reg. Dist. No. 185

10722

FOR STATE
HEALTH DEPT.

M

99

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u> ✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dr. Hartford Memorial Hosp</u>		d. STREET ADDRESS <u>XXXXXX R.D. 1</u>	
3. NAME OF DECEASED (Type or print) <u>Thomas Tibbs</u>		4. DATE OF DEATH <u>October 11 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>20 April 1949</u>
9. AGE (In years last birthday) <u>8</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. Robert Tibbs Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Mildred Walter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>** ** *</u>	
17. INFORMANT <u>J. Robert Tibbs Sr.</u>		Address <u>R.D. 1 Havre de Grace</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>G.S.W. Chest</u> <u>9190</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Md.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Accidentally shot by brother</u>	
20c. TIME OF INJURY Month, Day, Year <u>10-11-57</u> Hour <u>5</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Hartford</u> (County) <u>Hartford</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Ronald E Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md.</u>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/15/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>		22d. LOCATION (City, town, or county) (State) <u>R.D. Bel Air, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Barring</u>		24a. REC'D BY REGISTRAR <u>DATE 10-15-57</u>	
ADDRESS <u>Aberdeen, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>G. H. Palmer</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

OCT 17 1957

RECEIVED

10738

CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH o. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				c. LENGTH OF STAY IN 1b 5 Yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital Aberdeen Proving Ground				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle JOSEPH Last TROPEA				4. DATE OF DEATH Month October Day 30 Year 1957			
5. SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 Oct 57		9. AGE (In years lost birthday) yrs. 25		10. IF UNDER 1 YEAR Months 2 Days 25
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Ralph Frank Tropea			
14. MOTHER'S MAIDEN NAME Shizuko Hara				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT Mother (Same as in 2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature Birth 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH —
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. p. Month, Day, Year 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from 30 October , 19 57 , to 30 Oct , 19 57 , that I last saw the deceased alive on 30 October , 19 57 , and that death occurred at 2145 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Joseph M. Silverstein M.D.				ADDRESS (Street, city or town, state) US ARMY HOSPITAL ABERDEEN PROVING GROUND, Md			
DATE SIGNED							
PHYSICIAN'S NAME (Type) JOSEPH M SILVERSTEIN CAPT MC							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/4/57		22c. NAME OF CEMETERY OR CREMATORY A.C.C. Post Cemetery		22d. LOCATION (City, town, or county) (State) Army Chemical Center, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Lanning				ADDRESS Aberdeen Md		24a. REC'D BY REGISTRAR Nov 2-57	
				24b. REGISTRAR'S SIGNATURE Willie K. Perry			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2050282XVO

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CLERK	
JAMES EARL RAY		Male		35		White		Salesman		Memphis, Tenn.		April 4, 1968		April 4, 1968		Nashville, Tenn.		Heart Disease		Suicide		[Signature]		[Signature]		[Signature]	
15. MARITAL STATUS		16. EDUCATION		17. RELIGION		18. ETHNIC ORIGIN		19. SOCIAL SECURITY NO.		20. MEDICAL RECORD NO.		21. HUSBAND'S NAME		22. WIFE'S NAME		23. CHILDREN'S NAMES		24. OTHER INFORMATION		25. COMMENTS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF CLERK		28. SIGNATURE OF PHYSICIAN	
Single		High School		Protestant		American		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Signature]		[Signature]		[Signature]	

RECEIVED
NOV 5 1967
BUREAU V. S.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10736/85
Reg. Dist. No.

10723

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Harford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford de Grace DOA</u>		c. LENGTH OF STAY IN 1b <u>24</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford de Grace</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL</u>			d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Janet</u> First <u>Walter</u> Middle <u>Walter</u> Last			4. DATE OF DEATH Month <u>October</u> Day <u>18</u> Year <u>1957</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 14 - 1957</u>		9. AGE (In years last birthday) <u>27 days</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>			13. FATHER'S NAME <u>Harry Walter</u>		
14. MOTHER'S MAIDEN NAME <u>Mildred Skumater</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes, give war or dates of service</u>		
16. SOCIAL SECURITY NO. <u>-</u>			17. INFORMANT <u>Harry Walter</u> Address <u>Harford de Grace md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary hemorrhage</u> <u>771.0</u> DUE TO <u>unknown</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> (c) <u>-</u>					INTERVAL BETWEEN ONSET AND DEATH <u>-</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>-</u>	(County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air md.</u>		DATE SIGNED <u>10-19-57</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-20-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Elbton Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Elbton Cecil md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph P Grant</u>		ADDRESS <u>Northeast, md</u>		24a. REC'D BY REGISTRAR <u>Dr. H L Lewis</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1-1-53

NOT STATE
HEALTH DEPT.

RECEIVED
FEDERAL BOMB
BUREAU

BUREAU V. S.

OCT 22 1957

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10739 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10737

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY <u>Hanover</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>Dauphin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abers-reen</u>	c. LENGTH OF STAY IN 1b <u>1 day</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Palmyra 75x-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Salvage Area AP2</u>		d. STREET ADDRESS <u>Route 1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Ralph Eugene Wolfe</u>		4. DATE OF DEATH Month <u>October</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 18, 1926</u>
9. AGE (in years last birthday) <u>30</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer - Scrap Dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penna.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Levi Wolfe</u>		14. MOTHER'S MAIDEN NAME <u>Mary Kreiser</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes 1945-1947</u>		16. SOCIAL SECURITY NO. <u>163-22-0379</u>	
17. INFORMANT <u>Raymond Wolf-</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing injury chest</u> <u>910.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Part of aircraft he was solving fell on him</u>	
20c. TIME OF INJURY Month, Day, Year <u>3</u> Hour <u> </u> a.m. <u>10-15</u> 19 <u>57</u>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Salvage Area AP2</u>	20f. (City or town) (County) (State) <u>Hanford Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air, Md 10-16-57	
EXAMINER'S NAME (Type) <u>Gerald C. Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/14/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Fredericksburg Penna.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Fanning</u>		24a. REC'D BY REGISTRAR <u>Oct 17/57</u>	
ADDRESS <u>Abers-reen Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Mellie R Perry</u>	

MEDICAL CERTIFICATION

12

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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OCT 18 1957

BUREAU V. S.

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BOMB

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10738

Reg. Dist. No. 182

FOR STATE
HEALTH DEPT.

10724

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>			
c. LENGTH OF STAY IN 1b <u>20 yrs</u>		d. STREET ADDRESS <u>Emmorton Road</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Emmorton Road</u>		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>M. Harold Filmore Wright</u>		4. DATE OF DEATH <u>October-30</u> 19 <u>57</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 27-1863</u>			
9. AGE (In years last birthday) <u>93</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.			
11. BIRTHPLACE (State or foreign country) <u>Springfield, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Robert D Wright</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Perkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u>722 227-1863</u>			
17. INFORMANT <u>Wm Sadu W. Stephenson</u> Address <u>Bel Air, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Oedema</u> 904.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Bruise Skull</u> (c) <u>bruise skull</u> DUE TO cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fell + struck head</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>10-16</u> 19 <u>57</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Bel Air</u> (County) <u>Harford</u> (State) <u>md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md</u> DATE SIGNED <u>10-30-57</u>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Harford Co.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-1-57</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>St Mary's Episcopal</u>		22d. LOCATION (City, town, or county) <u>Emmorton Harford, Md.</u> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph T Foster</u> ADDRESS <u>Bel Air, Md.</u>		24a. REC'D BY REGISTRAR <u>10-31-57</u> 24b. REGISTRAR'S SIGNATURE <u>Priscilla Louwood</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1957

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO DISTRICT

DATE OF ENTRY INTO COUNTY

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BUREAU V. S.

NOV 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 10725 CERTIFICATE OF DEATH

10739
185

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAURE DE GRAVE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FALLSTON X0</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>		d. STREET ADDRESS <u>Box 116</u>	
3. NAME OF DECEASED (Type or print) First <u>FRANCES</u> Middle <u>A.</u> Last <u>WYKES</u>		4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 19, 1876</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Missouri, Kansas City, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MORRIS RUSSELL</u>		14. MOTHER'S MAIDEN NAME <u>HONORE RUSSELL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Jane Harvey</u>		Address <u>Fallston, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-5</u> , 19 <u>57</u> , to <u>10-7</u> , 19 <u>57</u> that I last saw the deceased alive on <u>10-5</u> , 19 <u>57</u> , and that death occurred at <u>2:40 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		DATE SIGNED <u>Bel Air, Md. 10-7-57</u>	
PHYSICIAN'S NAME (Type) <u>Gerald C Palmer</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct 10, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Odell Protestant</u>	
22d. LOCATION (City, town, or county) <u>Odell</u>		(State) <u>Illinois</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Archer</u>		ADDRESS <u>Benson Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE OCT 8 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. D. L. Lewis</u>	

MEDICAL CERTIFICATION

1957 8 OCT

RECEIVED